MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
VISION SCREENING PROGRAM

VISION TECHNICIAN OBSERVATION FORM

Vision Technician: _____

Phone: _____ Cell: _____

Email: _____

Date of Comprehensive Training: _____

PRESCHOOL: _____

Address: _____

City: _____

Phone: _____

SCHOOL-AGE: _____

Address: _____

City: _____

Phone: _____

Health Department: _____

Coordinator/Supervisor: _____

Phone: _____ Fax: _____

TAP Evaluator: _____

Date: _____

This packet is to be reviewed prior to meeting with the TAP Evaluator. Please bring it with you to your scheduled site as it is used during the review process.